I authorize **Dr. Jill Miller/ Dr. Gigi Kates** to perform laser hair removal treatment on me.

The Lightsheer produces a beam of highly concentrated light that is well absorbed by the pigment located in the hair follicle. To protect my eyes from the laser, I will have my eyes covered with protective glasses. I will have a gel on my skin and then feel a hot pulse from the laser.

I have been informed that scarring, blistering, purpura, lightning or darkening of the skin are possible side effects from this procedure. Usually, if these occur, they are temporary and can resolve in a few days or weeks. Skin discoloration may be permanent although rare.

I have been informed that multiple treatments are necessary.

I understand that immediately following the laser treatments the treated area will appear as red discoloration and maybe swollen, which may last up to 2 hours or longer. The redness may last up to 2-3 days. The treated area may feel like a sunburn or a few hours after the treatment.

I have read and understood all the information presented to me, and all of my questions have been answered.

Signed: _____ Date:_____

Client or person legally authorized to consent for client)

Parent (guardian): _____ Date:_____

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